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ABSTRACT

When training counseling students, it is important to familiarize them with the clinical research literature exploring the efficacy of particular treatments. The bulk of the document is comprised of a review of empirically supported treatments (ESTs). ESTs or evidence-based treatments are grounded in studies recommended by the American Psychological Association. To qualify for inclusion in this EST listing, research must have shown that it leads to a reduction or remission of the disorder or problem at a rate higher than occurs with the passage of time, or that it outperforms an alternative active treatment. Knowledge of a treatment that has been shown to be efficacious should affect decisions about how one practices psychotherapy. ESTs are examined in the following areas: managed psychotherapy work, alcoholism treatments, patient-treatment matching, therapeutic alliance, opiate addiction, the role of families in treating substance abuse, and family therapy. (Contains approximately 115 references.) (MKA)

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Familiarizing Students with the Empirically Supported Treatment Approaches for Substance Abuse Problems

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In training counseling students, it is increasingly important to acquaint them with the clinical research literature exploring the efficacy of particular treatments. This review of empirically supported treatments (ESTs) is intended to facilitate this educational process. ESTs, or evidence based treatments, are based on studies recommended by Division 12 of the American Psychological Association in their report on empirically validated psychological treatments (Chambless et al., 1996; Task Force on Promotion and Dissemination of Psychological Procedure, 1995). The original listing was recently expanded to include 57 treatments that had withstood the test of careful empirical scrutiny (Chambless & Hollon, 1998). Developing specific psychotherapeutic techniques for homogeneous populations is a current focus of psychotherapy research (Orlinsky & Howard, 1986).

To qualify for inclusion in the EST listing, for each treatment research must have shown that it leads to a reduction or remission of the disorder or problem at a rate higher than occurs with the passage of time (efficacious) or that it outperforms an alternative active treatment (efficacious and specific). Knowledge that a treatment has been shown to be

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efficacious should affect decisions about how one practices psychotherapy.

Using Treatment Guidelines

Clinical practice guidelines based on laboratory research, outcome data, and cost containment needs are becoming increasingly common. Their use raises several serious practical and ethical questions. How can guidelines be customized to meet the specific needs of particular clients? How can we tailor treatments without compromising their established efficacy? How can clinicians preserve their own creativity and spontaneity while adhering to treatment guidelines? How can clinicians stay attuned to the idiosyncracies of individual cases while employing treatment protocols? How can clinicians avoid becoming distracted and myopic in using treatment guidelines? How can clinicians accommodate the need to provide "partial" treatment?

While the guidance offered by these treatment literatures is invaluable, it is not enough simply to memorize a treatment protocol or manual and deliver it when we meet someone with the appropriate diagnosis. The need to customize the ESTS in light of individual learning styles and preferences, the existence of codiagnoses, and other mediating variables, will help to keep psychotherapy part "art" for some time to come!

Using ESTS in Making Managed Care Psychotherapy Work

Managed care providers are expected to adhere to treatment guidelines described in manuals provided by individual managed care companies. One of the frustrations associated with doing managed care work involves the lack of uniformity that exists across these guides. While all are derived from a common research literature on treatment efficacy, companies have worked independently to craft distinctive guidelines, which are considered proprietary. This restricts free and widespread access to this information, and has stymied development of consensual "industry standard" guidelines.

Although initially you may feel baffled by the need to comply with disparate instructions about how to proceed with clients carrying a particular diagnosis, as you review the different manuals, you will notice considerable overlap. To simplify your clinical work, you may wish to focus on mastering the conclusions from the empirical treatment literature. This body of research forms the basis for all the separate clinical manuals managed care companies have developed. If you can provide a case reviewer with the research basis for your treatment plan and process, minor deviations from the specific guidelines will generally be accommodated.

The following sections organize the treatment efficacy literature according to diagnostic category. Dually diagnosed clients will require some creative merging of techniques, unless their particular combination of problems has been specifically

addressed in the literature.

Studies selected for summary were taken from the national listing of Empirically Validated Treatments developed by the American Psychological Association. The criteria for inclusion in the APA sample is described in detail elsewhere, but priority was given to carefully controlled, double-blind, randomized studies with adequate sample size and measures to assure high treatment fidelity.

Most of the controlled studies of psychological treatments have been conducted on behavioral or cognitive approaches, although recently there has been increased use of clinical trials methodologies in tests of other treatment approaches, such as those based on psychodynamic theory.

Alcoholism

Research conducted over recent decades has supported the proposition that psychotherapy process variables are related to treatment outcomes (Orlinsky, Grawe, & Parks, 1994). An important focus of these empirical efforts has been the nature and quality of the therapeutic (or working) alliance and its relationship to treatment outcome. Although defined in a number of ways over the years, most definitions of the therapeutic alliance overlap in emphasizing a collaborative relationship between the client and therapist that consists of an emotional bond and a shared presumption regarding the tasks and goals of the treatment endeavor (e.g., Bordin, 1979; Greenson, 1967).

It also appears that rating of the therapeutic alliance at early stages of treatment are more predictive of outcome than are ratings taken later in the treatment process (Gomes-Schwartz, 1978; Hartley & Strupp, 1983; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). Furthermore, ratings of the alliance provided by the client have been stronger predictors of treatment outcome than ratings provided by the therapists (Horvath, 1994; Horvath & Symonds, 1991). Finally, the available research suggests that the relationship of the therapeutic alliance to outcome is evident across therapeutic modalities. Horvath and Symonds (1991) investigated this question in their review and found that the relationship between alliance and outcome appears robust across several types of psychotherapy (e.g., psychodynamic, cognitive, eclectic).

MATCH

Project MATCH was a national multisite clinical trial designed to evaluate hypotheses relating to patient-treatment matching. Two independent but parallel matching studies were conducted, one with clients recruited from outpatients settings (n = 952), the other with clients receiving aftercare treatment after inpatient care (n = 774). After baseline assessments, clients were randomly assigned to one of three 12-week

treatments: 12-step facilitation (TSF), cognitive-behavioral coping skills treatment (CBT), or motivational enhancement therapy (MET). The clients were followed at 3-month periods for the year after the treatment period. At the 12-month posttreatment follow-up, 92% of the living outpatients and 93% of the living aftercare clients were interviewed. In addition, several within-treatment process assessments were conducted.

Treatments

TSF is based on the concept of alcoholism as a spiritual and medical disease with stated objectives of fostering acceptance of the disease of alcoholism, developing a commitment to participate in Alcoholics Anonymous, and beginning to work through the 12 steps. CBT is grounded in social learning theory and on the view of drinking behavior as functionally related to major problems in an individual's life, with emphasis placed on overcoming skills deficits and increasing the ability to cope with situations that commonly precipitate relapse. MET is based on principles of motivational psychology and focuses on producing internally motivated change. This treatment is not designed to guide the client step by step through recovery; instead, it utilizes motivational strategies to mobilize the individual's own resources.

Working Alliance Inventory

The WAI (Horvath & Greenberg, 1986) was used to assess the therapeutic alliance. The WAI is a 36-item measure that consists of three subscales that address the goals of therapy (Goal), agreement about the tasks of therapy (Task), and the bond between the client and therapist (Bond). Ratings are made on a 7-point Likert-type scale ranging from 1 (never) to 7 (always) on the extent to which the respondent agrees with the statement, and a global score is calculated by taking the sum of the 36 items (after accounting for reverse-scored items).

In a study among outpatient alcoholic clients, Connors, Carroll, DiClemente, Longabaugh, and Donovan (1997) found that therapeutic alliance consistently predicted treatment participation and positive drinking-related outcomes, whether the alliance was rated from the client or therapist perspective.

Alcohol Self-Control

Behavioral self-control training (BSCT) is a treatment that teaches individuals how to change their drinking behaviors, usually to achieve a goal of moderate and nonproblematic drinking. The behavioral techniques include goal setting, self-monitoring, rate control, setting rewards for achieving one's goals, functional analysis of drinking situations, learning alternate coping skills, and relapse prevention. There have been 30 controlled clinical trials of BSCT, more than of any other treatment for alcohol problems. Its effectiveness has been well

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established (see Hester, 1995; Miller et al., 1995, for reviews). Client characteristics predictive of success include less severe alcohol-related problems and a shorter duration of drinking problems (Miller & Baca, 1983). These client characteristics predict success both at initial follow-ups up to 12 months and at long-term follow-ups of 2 to 8 years (Miller, Leckman, Delaney, & Tinkcom, 1992). Overall, the data from controlled clinical trials provide compelling evidence that BSCT is an effective intervention for what some characterize as "early stage problem drinkers."

Studies that have compared the different modes of delivery (individual, group, and bibliotherapy with minimal therapist supervision) have not found any significant advantage of one over another. Because BSCT is an effective intervention for drinkers with less severe alcohol-related problems, it makes sense to investigate ways in which a greater number of drinkers could learn these strategies in a nonthreatening, cost-effective, and time-efficient manner.

Hester and Delaney (1997) found that individuals who received a computer-based BSCT program significantly reduce their drinking relative to individuals in a control group who were interested in moderating their consumption but did not receive the training immediately. These changes in drinking behaviors include fewer drinks per week and fewer drinks per drinking day. The changes in drinking were clinically meaningful as well as statistically significant. Before beginning treatment, participants were drinking, on average, the equivalent of a six-pack of beer per drinking day. Treatment with the computer program resulted in a drop in consumption to a little over three beers per drinking day. Hester and Delaney also observed a general decline in other drug use. The Hester and Delaney (1997) study indicates that computer-based self-control training may be as effective as other methods of delivering this protocol.

Opiate Addiction

Woody, G. E., Luborsky, L., McLellan, A. T., & O'Brien, C. P. (1990). Corrections and revised analyses for psychotherapy in methadone maintenance patients. Archives of General Psychiatry, 47, 788-789.

In a prior study that compared two forms of professional psychotherapy and drug counseling as treatment for methadone-maintained opiate addicts, Woody, Luborsky, McLellan and O'Brien learned that several mistakes had been made in the interpretation of the data. The first problem was a type setting error that omitted the line of original data values for the Maudsley Neuroticism Scale and shifted the other data lines down one row. Another error was made in the actual values presented for the Symptom Checklist 90- Item Scale were inaccurate. The last problem was that the changes in the way that the Addiction Severity Index (ASI) composite scores were calculated during the

years of 1979 to 1986 made it difficult to compare those values from the 1983 study with those in subsequent studies.

In order to correct these errors, the entire data set was reexamined. Data on 10 of the subjects of the 110 who participated, was lost sometime during the 7 years since the original study was done. Once the data set was reconstructed the major analyses were repeated. The patterns established from this data set was in fact very similar to the original results although several factors had different significances. When between group comparison were performed they found 7 significant differences. In all of the significant differences the Drug Counseling group showed worse adjusted outcomes than the two therapy groups. The two therapy groups showed no differences between the two. This is contrary to the original study.

After the reanalysis of the data, although there were some differences the conclusions of the original paper were not affected by this reanalysis. However, the important qualification that there are no differences in drug use outcomes is now added to the study after the reanalyses. These differences are probably a result of the more rigorous scoring guidelines for the ASI , the loss of subjects and the errors in the original analyses.

Smoking Cessation

Individual and group counseling is critical to helping smokers quit, according to new clinical guidelines on smoking cessation interventions recently issued by the Agency for Health Care Policy and Research (AHCPR) and the Centers for Disease Control (CDC). To develop Smoking Cessation Clinical Practice Guidelines, AHCPR and CDC convened an expert panel of 19 physicians and other health care and health education professionals to review and analyze the scientific literature to identify effective, validated treatments and practices (Goetz, ACA Public Policy and Information, 1997). Approximately 300 peer-reviewed articles published between 1975 and 1994 that described randomized, controlled trials using smoking cessation interventions were reviewed and analyzed. The first draft of the guidelines were then reviewed and commented upon by 71 peer reviewers from various disciplines. The panel amended the guidelines to reflect these comments. The resulting AHCPR/CDC guidelines recommend that, in order to be most effective, smoking cessation interventions should include either individual or group counseling. The content of the counseling, according to the panel, should focus on developing general problem-solving, relapse prevention and stress management skills. Social support provided by a clinician as part of the counseling relationship is also important.

Generally, the panel found that the effectiveness of counseling in promoting smoking cessation was directly related to its intensity and duration. The guidelines recommend four to seven individual or group counseling sessions to be most

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effective. The AHCPR/CDC panel declined to endorse any particular mental health discipline to provide smoking cessation counseling, concluding that there was insufficient scientific evidence to recommend one or more disciplines over any other. In addition to counseling and other psychosocial interventions, the guidelines recommend the use of nicotine patches or gum in helping smokers to quit. Aversive smoking, which involves multiple sessions in which a client smokes intensively to the point of discomfort, was also judged effective with appropriate medical screening and supervision. The panel found that there was insufficient scientific evidence to support its endorsement of other types of interventions sometimes used to support smoking cessation, including hypnosis, acupuncture and antidepressant drugs.

The AHCPR/CDC expert panel also recommended that: All physicians should routinely ask their patients if they smoke and strongly advise any patient who smokes to quit. The panel also recommends that other non-physician healthcare professionals, including professional counselors, address smoking as part of their encounters with clients. Advice of this kind was found to be effective in promoting smoking cessation. Current research indicates that half of the smokers in the United States have never discussed their smoking with a healthcare professional. Smokers who have mental or emotional disorders, such as depression or chemical dependence, should be encouraged to quit smoking and treated with the same interventions as other populations. While there is some clinical evidence that smoking cessation may exacerbate some disorders, the panel concluded that any adverse impact is minimal. It also found that there is little evidence that smokers with alcohol or other chemical dependencies relapse to other drug use when they quit smoking.

Smoking cessation interventions should be tailored or modified to be appropriate for the racial and ethnic populations with which they are used. Counseling and other smoking cessation treatments should be reimbursed by health insurance and managed care corporations.Counseling and other treatments judged effective by the panel for use with adults should be also be considered for use with children and youth who smoke. Nicotine patches and gum should only be used if the child or adolescent is genuinely dependent on nicotine and is committed to quitting. A separate set of guidelines is being developed to identify effective approaches to preventing smoking among young people.

To assist professional counselors and other health care professionals in helping their clients to quit smoking, AHCPR has developed a free Smoking Cessation Consumer Tools Kit that includes four black-and-white, one-page handouts that address particular concerns of smokers. The Tools Kit and a copy of the Smoking Cessation Clinical Practice Guidelines can be obtained through the AHCPR Clearinghouse by calling 800-358-9295 or by writing to AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907-8547. The Smoking Cessation Clinical Practice Guidelines can also be found at CDC's Office of Smoking

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and Health web site at: http://www.cdc.gov/tobacco.

Nicotine replacement therapy (NRT) is the state-of-the-art treatment for nicotine addiction. The growth in interest in the use of NRT stems from three observations: (a) Compulsive tobacco use involves physiological and behavioral dependence on nicotine, (b) nicotine need not be delivered by tobacco to produce its effects, and (c) NRT for nicotine addiction can be accomplished in a manner that permits therapeutic management of the dependence process and lessens the overall health risk to the user (Henningfield & Jasinski, 1988).

Nonetheless, the addition of behavioral treatment to NRT significantly increases long-term smoking cessation rates (Hughes, 1991). Indeed, NRT has been shown to be most effective when combined with intensive, clinic-based behavioral interventions designed to facilitate the development of self-regulator skills (Hall, Tunstall, Ginsberg, Benowitz, & Jones, 1987; Hall, Tunstall, Rugg, Jones, & Benowitz, 1985; Killen, Maccoby, & Taylor, 1984; Kozak & Fagerstrom, 1995; Schneider et al., 1983).

The evidence with respect to nicotine gum (NG) and clinic-based behavioral treatment combinations is conclusive. Both standard and meta-analytic reviews have concluded that NG is a useful pharmacological aid to smoking cessation when combined with behavioral treatment programs delivered through smoking cessation clinics (Hughes, 1991; Lam, Sacks, Sze, & Chalmers, 1987). However, abstinence rates are far less impressive when NG is delivered in general medical practice in conjunction with brief counseling interventions (British Thoracic Society, 1983; Hughes, Gust, Keenan, Fenwick, & Healey, 1989).

Compliance with treatment instructions is an important mediator of treatment outcome. There is evidence that compliance to TNP protocol is far from complete. For example, in one large trial with over 1,600 smokers, more than half discontinued patch use before the end of the 12-week intervention (Imperial Cancer Research Fund General Practice Group, 1993). Other investigators have also reported substantial deviations from TNP treatment protocols (Kozak & Fagerstrom, 1995; Westman et al., 1993). Killen, Fortmann, Davis, & Varady (1997) report that although NRT has improved our ability to produce smoking cessation, the production of sustained, longer term abstinence remains and elusive goal.

The Role of Families in Treating Substance Abuse

Stanton & Shadish (1997) conducted a meta-analytic review of fifteen controlled, comparative studies of treatments for drug abuse that included a family-couples treatment condition. Across the 1,571 cases (involving approximately 3,500 patients and family members), family therapy was found to be superior to individual counseling or therapy, peer group therapy, and family psychoeducation. Family therapy was found as effective for adults

as for adolescents, and appeared to be a cost-effective adjunct to methadone maintenance. Family therapy was also associated with higher retention rates than other treatment modalities.

Although early characterizations of drug abusers depicted them as "loners", 26 out of 28 recent studies have found "drug addicts" to have regular contact with one or more of their parents or parent surrogates (Stanton, 1997). Terrell (1993) and Bowser and Word (1993) argue that nuclear and extended families are an untapped resource in the treatment and prevention of substance abuse among Hispanic and African American groups. Several family factors have been linked to the addictive process. Onset of drug abuse may be precipitated by family disruption, stresses, and losses (Duncan, 1978; Noone, 1980), and parental modeling of drug-alcohol use has been found to be influential (Gorsuch & Butler, 1976). Family members often engage in "enabling" behaviors that perpetuate abuse, and abuse may help to maintain family homeostasis (Craig, 1993). Although the focus of much research has been on male drug abusers, several studies have shown the role of romantic partners and family members in the onset of drug use by women (Brunswick, Lewis, & Messeri, 1991). In addition, for many addicted mothers, their children provide the strongest reason for curtailing use.

Most family-couples therapy outcome research on this population has been performed with some version of structural (Minuchin, 1974), strategic (Haley, 1980), or structural-strategic (Stanton, 1981) family therapy. Structural therapy works toward altering family structure through in-session interactions among various family members, whereas strategic approaches attend more to family interactions outside the session, along with the assignment of therapeutic tasks designed to alter those interactions (Hazelrigg, Cooper, & Borduin, 1987).

Family Therapy Outcomes

Clients receiving family-couples therapy manifested significantly lower drug use after treatment than did clients in nonfamily therapy, alternative interventions (Stanton & Shadish, 1997). Interestingly, Szapocznik et al (1986) found that a one-person approach, in which only the therapist and the client meet to focus on family oriented content, was as effective as standard, conjoint sessions, although the one person approach took significantly more sessions to achieve the outcome. Ecological family therapy, including direct interventions in external systems such as schools and neighbors in addition to the family, was no better than an intramural version where interventions were confined to the nuclear family (Scopetta, King, & Szapocznik, 1979).

Compared with other approaches to psychotherapy with drug abusers, family therapy conditions have attained the highest rates of engagement and retention in treatment. Relatives' groups seem to do about as well as family therapy (Friedman, 1989; Ziegler-Driscoll, 1977), although relatively few studies have

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examined this mode of intervention.
Brief family psychoeducation was not as effective as family therapy. Psychoeducation was found to be superior to peer group therapy in one study (Joanning et al, 1992), but inferior in a second study (Liddle et al, 1995).

Stanton, Steier, Cook, and Todd (1984) have shown the cost benefits of recruiting families for treatment, and how home detoxification from methadone is considerably more cost-effective than inpatient detoxification, given proper professional and medical backup. Trepper, Piercy, Lewis, Volk, and Sprenkle (1993) found family therapy to be more cost-effective because it took an average of 11 sessions to get results similar to those achieved by 19 sessions of individual therapy. However, mobilizing larger systems to convene such therapy has its own additional costs in terms of collateral phone calls, planning, use of multiple therapists and the like. The one person family-focused approach advocated by Szapocznik, Kurtines, Santisteban, and Rio (1990), where most sessions do not require the convening of all family members, may offer an attractive cost-effective compromise. Fals-Stewart, O'Farrell, and Birchler (1998) obtained substantial and concrete savings by switching behavioral couple sessions for a portion of clients' individual sessions.

Summaries of Additional Research on ESTs for Substance Abuse
(References from the EST list are organized alphabetically)

Azrin, N. H. (1976). Improvements in the CR approach to alcoholism. Behaviour Research and Therapy, 14, 339-348.

Azrin (1976) compared the Community-Reinforcement program with a modified Community-Reinforcement program for treating alcoholics. The original Community-Reinforcement program (Azrin, Flores, & Kaplan, 1975; Azrin, Naster, & Jones, 1973; Hunt & Azrin, 1973) entailed special job, family, social, and recreational procedures. The modified program included, in addition to the above features, a Buddy system, daily report procedure, group counseling, and a special social motivation program to ensure the self-administration of Disulfiram (Antabuse). The results of this study showed that those in the modified Community-Reinforcement program worked more, drank less, spent less time being institutionalized, and spent more time at home. Overall, the modified program took less time and was more effective than the original program.

Carroll, K. M., Rounsaville, B. J., Gordon, L. T., Nich, C., Jatlow, P., Bisighini, R. M., & Gawin, F. H. (1994). Psychotherapy and pharmacology for ambulatory cocaine abusers. Archives of General Psychiatry, 51, 177-187.

Carroll, Rounsaville, Gordon, Nich, Jatlow, Bisighini, and Gawin (1994) compared psychotherapy and pharmacotherapy, alone and combined, in treating ambulatory cocaine abusers. More

specifically, they examined relapse prevention plus desipramine hydrochloride, clinical management plus desipramine, relapse prevention plus placebo, and clinical management plus placebo. Subjects in the desipramine conditions initially received 50 mg of desipramine hydrochloride, 200 mg/day after the first week, and then a maximum of 300 mg/day. The relapse prevention method included reducing exposure to cocaine and its cues, understanding the positive and negative outcomes of continuing cocaine use, identifying high-risk circumstances for relapse, recognizing craving and developing coping strategies, identifying "irrelevant" decisions about high-risk circumstances, preparing for emergencies and relapse, and creating alternative activities (Marlatt & Gordon, 1985; Carroll, 1987). The clinical management method consisted of supportive doctor-patient relationship, education, empathy, medication management, and a convincing therapeutic rationale of treatment (Fawcett et al., 1987). The results showed that while all groups showed significant improvement, main effects were not found for medication, psychotherapy, or their combination.

Cinciripini, P. M., Lapitsky, L. G., Wallfisch, A., Mace, R., Nezami, E., & van Vunakis, H. (1994). An evaluation of a multicomponent treatment program involved scheduled smoking and relapse prevention procedures: Initial findings. Addictive Behaviors, 19, 13-22.

Cinciripini, Lapitsky, Wallfisch, Mace, Nezami, and van Vunakis (1994) compared a scheduled smoking procedure with a minimal contact self-help treatment control in smoking cessation. The scheduled procedure method consisted of subjects using either scheduled smoking and relapse prevention (Cinciripini & Lapitsky, 1991) or the American Cancer Society "I Quit Kit" (ACS, 1977). The self-help method included either no formal behavioral training or the "I Quit Kit". The results showed that after 6 and 12 months, 53% and 41%, respectively, of the scheduled smoking group experienced abstinence. Only an average of 6% of the control group experienced the same.

Cinciripini, P. M., Lapitsky, L. G., Seay, S., Wallfisch, A., Kitchens, K., & van Vunakis, H. (1995). The effects of smoking schedules on cessation outcome: Can we improve on common methods of gradual and abrupt nicotine withdrawal? Journal of Consulting and Clinical Psychology, 63, 388-399.

Cinciripini, Lapitsky, Seay, Wallfisch, Kitchens, and Van Vunakis (1995) compared scheduled reduced smoking, nonscheduled reduced smoking, scheduled nonreduced smoking, and nonscheduled nonreduced smoking in the cessation of smoking behavior. The scheduled reduced method entailed smoking only at designated times of the day with the time between smoking gradually increasing. The nonscheduled reduced smoking method included

gradually decreasing the consumption of cigarettes by using a weekly reduction quota. The scheduled nonreduced method consisted of the same smoking schedule as the first method; however, there was not any reduced smoking markers. Participants in this group had to stop smoking abruptly on a target date. The final group (nonscheduled, nonreduced) were not set any guidelines besides the baseline level and were made aware that they would have to quit "cold turkey" at the target date (Cinciripini & Lapitsky, 1991). All participants also received cognitive-behavioral therapy. The results indicated that, after a year, the scheduled reduced method showed the most effectiveness while the nonscheduled reduced method exhibited the least. Methods containing schedules were more effective than those without schedules.

Drummond, D. C., & Glautier, S. (1994). A controlled trial of cue exposure treatment in alcohol dependence. Journal of Consulting and Clinical Psychology, 62, 809- 817.

Drummond and Glautier (1994) compared cue exposure (CE) with relaxation control (RC) in the treatment of alcohol dependence. The CE method included a cue hierarchy of a high-salience alcohol stimulus, a low-salience alcohol stimulus, and a neutral stimulus. Subjects were then exposed to the alcohol stimuli for 40 minutes a day and then the neutral stimulus for 10 minutes a day until a total of 400 minutes of alcohol stimulus exposure was reached (200 minutes of low-salience stimulus and 200 of high-salience stimulus). The RC method entailed exposure to alcoholic and neutral stimuli for 5 minutes for each stimulus only on test days. Total exposure to alcohol was 20 minutes. For the rest of the each session, subjects relaxed and on an additional six days, this group experienced Progressive Relaxation Training (Bernstein & Borkovek, 1973). The results indicated that the CE group had a greater latency to relapse into heavy drinking and a lower level of total alcohol consumption than did the RC group at a 6-month follow-up.

Eriksen, L., Bjornstad, S., & Gotestam, K. G. (1986). Social skills training in groups for alcoholics: One-year treatment outcome for groups and individuals. Addictive Behaviors, 11, 309-329.

Eriksen, Bjornstad, and Gotestam (1986) compared a social skills training group (SSTG) with a control group. The SSTG method involved instruction, modeling, behavioral rehearsal, feedback, individualized role-playing and real-life homework assignments to increase the clients' social skills and assertiveness, with the assumption that these behaviors can be alternatives to drinking (Liberman, King, DeRisi, & McCann, 1975; Miller & Mastria, 1977; Rose, 1977). The control group was

dispersed into four existing discussion groups, whose focus was alcohol topics. The results indicated that SSTG group members: drank 2/3 of the amount of pure alcohol than did the control group; had two times the number of sober days and working days as the control group; and had a greater length of abstinence after discharge than the control group. The SSTG group, however, drank almost twice as much as the control group members on drinking days.

Higgins, S. T., Budney, A. J., Bickel, W. K., Hughes, J. R., Foeg, F., & Badger, G. (1993). Achieving cocaine abstinence with a behavioral approach. American Journal of Psychiatry, 150, 763-769.

Higgins, Budney, Bickel, Hughes, Foerg, and Badger (1993) compared community reinforcement behavioral treatment with disease-model drug abuse counseling. The behavioral method (Sisson & Azrin, 1989) included reinforcement for initial abstinence through the acquisition of retail items and activities (first 12 weeks) and then one state lottery ticket for every urine sample testing negative for cocaine (second 12 weeks). Subjects were also given restructuring advice, positive alternatives, information on the negative consequences of cocaine use, skills training, AIDS prevention counseling, and employment and education counseling (Azrin & Besalel, 1980). Subjects who had a spouse, friend, or relative who was not a drug-abuser also received reciprocal relationship counseling (Azrin, Naster, & Jones, 1973). The drug abuse counseling method entailed supportive and confrontive therapy, didactic lectures, videotapes, family member involvement, relapse prevention, and self-help sponsor (Narcotics Anonymous, 1988). The results showed that the behavioral treatment method was superior to the counseling method in terms of treatment completion and continuous cocaine abstinence.

Hill, R. D., Rigdon, M., & Johnson, S. (1993). Behavioral smoking cessation treatment for older chronic smokers. Behavior Therapy, 24, 321-329.

Hill, Rigdon, and Johnson (1993) investigated four treatments: behavioral training, behavioral training and nicotine gum, behavioral training and physical exercise, and physical exercise. Behavioral training involved detailed information about the health risks related to smoking, removing smoking cues (ashtray, matches), and setting a definitive quitting date in which all participants signed a contract. They attended twelve 90-minute sessions in which they discussed hazards, temptations, and consequences of smoking. Nicotine gum was given to some with behavioral training on a weekly basis where the subjects were urged to chew the gum daily to avoid the want to smoke. Some

subjects with behavioral training also exercised. They spent 45 minutes, three days a week walking to increase their heart-rate. A placebo group spent 45 minutes exercising without any additional behavioral training. Percent of smokers quitting, respectively was 31.8, 36.4, 27.8, and 10.0. Behavioral training caused a greater cessation over the exercise only program.

Hunt, G. M., & Azrin, N. J. (1973). A community reinforcement approach to alcoholism. Behaviour Research and Therapy, 11, 91-104.

Hunt and Azrin (1973) compared a Community-Reinforcement procedure with a matched control group for the treatment of alcoholism in hospitalized alcoholics. The CR method entailed vocational counseling (Dreese, 1960; Jones & Azrin, 1972; Sheppard & Belitsky, 1966), marital and family counseling (Manson & Lerner, 1962; Ellis, 1966; Stuart, 1969; Ayllon & Azrin, 1968), social counseling, reinforcer-access counseling, existing hospital programs, and community maintenance. The results indicated that subjects in the treatment group drank less, worked more, and experienced more family and out-of-hospital time.

Law, M., & Tang, J. L. (1995). An analysis of the effectiveness of interventions intended to help people stop smoking. Archives of Internal Medicine, 155, 1933-1941.

Law and Tang (1995) analyzed 188 randomized controlled trials of smoking cessation interventions. Personal advice and encouragement to stop smoking by physicians, behavior modification therapy, pharmacological treatments to allay withdrawal symptoms, and gradual nicotine intake. The results found that personal advice from a physician, with repeated encouragement, improved the likelihood of smoking cessation success. Nicotine replacement therapy should also be used. Behavior modification therapy was not shown to contribute significantly to smoking cessation.

Lichtenstein, E., & Glasgow, R. E. (1992). Smoking cessation: What have we learned over the past decade? Journal of Consulting and Clinical Psychology, 60, 518-527.

Lichenstein and Glasgow (1992) discussed developments in understanding smoking and smoking cessation, methodological issues, and intervention approaches over the past 10 years. Although effective multisession clinic interventions have been developed, such programs reach relatively few smokers. This has led to self-help, work site, health care setting, and community interventions aimed at delivering less intensive programs to

larger populations. Conceptual and empirical developments and trends within these above delivery contexts are reviewed, and avenues of research are identified. Nicotine replacement strategies have benefitted from technological advances (e.g., transdermal patches) and present continuing challenges with respect to integration with behavioral strategies and incorporation into primary care medical settings.

O'Farrell, T. J., Cutter, H. S. G., Choquette, K. A., Floyd, F. J., & Bayog, R. D. (1992). Behavioral marital therapy for male alcoholics: Marital and drinking adjustment during the two years after treatment. Behavior Therapy, 23, 529-549.

O'Farrell, Cutter, Choquette, Floyd, and Batog (1992) compared behavioral marital therapy (BMT), an interactional couples therapy group, and a no-marital-treatment control group in relation to the treatment of married male alcoholics. The BMT method included weekly homework assignments, behavioral rehearsal (Antabuse Contract), encouragement of couple and family activities, and learning communication skills (O'Farrell et al., 1985). The interactional couples therapy was that used in prior studies (Steinglass, 1976; Blinder & Kirschenbaum, 1967; Gallant, Rich, Bey, & Terranova, 1970; McCrady, Paolino, Longabaugh, & Rossi, 1979). All subjects received alcohol counseling. The results showed that the BMT group experienced better marital outcomes (wives' positive marital adjustment and less time separated) than the no-treatment group, although the impact of these outcomes decreased with time after treatment. No advantage of BMT over alcohol counseling was observed after treatment.

O'Farrell, T. J., Cutter, H. S. G., & Floyd, F. J. (1985). Evaluating behavioral marital therapy for male alcoholics: Effects on marital adjustment and communication from before to after treatment. Behavior Therapy, 16, 147-167.

O'Farrell, Cutter, & Floyd (1985) compared behavioral couples therapy, interactional couples therapy, and a no-marital treatment control for marital adjustment and communication in alcoholic males. The behavioral method entailed creating an Antabuse contract, planning shared activities, acknowledge caring behavior, learning to listen, express feelings, and use planned communication, and using positive requests, compromise, and written agreements (O'Farrell & Cutter, 1979, 1984, in press). The interactional method consisted of mutual support, sharing of feelings, problem solving, discussion, verbal insight, homework assignments, written agreements, and Antabuse contracts (Steinglass, 1976; Gallant, Rich, Bey, & Terranova, 1970; McCrady, Paolino, Longabough, & Rossi, 1979). The results showed that the behavioral marital therapy group improved on desired relationship change, marital stability, and positiveness of

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communication measures. The interactional marital therapy group improved on desired relationship change and positive communication measures. The control group did not show any improvement on any of the measures. The behavioral therapy was superior to the interactional therapy on overall marital adjustment and was found to be multivariably different from the interactional group.

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Stevens and Hollis (1989) compared relapse prevention coping strategies, a discussion control, and a no-treatment control condition for participants trained in behavioral and cognitive smoking cessation techniques. All participants went through smoking cessation. The coping strategies entailed positive behavioral, cognitive, and social alternatives to smoking, as well as rehearsal through role playing, use of props, and imagery techniques. The discussion condition included discussion of problems and experiences and also provided social support. Results showed biochemically-confirmed higher abstinence rates for the coping strategies group.

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